

Last Name: _____ **First Name:** _____ M F **DOB (dd/mm/yy):** _____
Address: _____ **City:** _____ X _____ **Postal Code:** _____
Telephone: D: _____ **E:** _____ **Language Barrier:** YES NO
Health Card Number: _____ Identifies as First Nations, Inuit, Metis **Language Spoken:** _____
Primary Care Provider Name and Phone Number: _____

DIABETES ASSESSMENT (please check all that apply)

URGENT Type 1 High Risk for DM **If PREGNANT check below:**
 Symptomatic Type 2 _____ Type 1 Repeat GDM **Due Date:** _____
 New Diagnosis (<1 yr) Pre-diabetes No Previous Type 2 High Risk **Hospital:** _____
 Established (>1yr) Steroid induced Education GDM Postpartum

REASON FOR REFERRAL (please check all that apply)

Diabetes Education Weight Control Insulin Start – See Order Below Insulin Adjustment Education
 Poor Diabetes Control Carb Counting Insulin Pump Foot Care Education
 Experiencing Hypoglycemia Lipid Management CGMS AGP/Flash Foot Care Treatment
 Pre-Pregnancy Counselling Sick Day Management GLP-1 Start – See Order Below Other _____

ORDERS FOR INSULIN and/or GLP-1 INITIATION AND/OR ONGOING ADJUSTMENTS

Insulin Type:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____ or
Dose and Time:		<input type="checkbox"/> Adjust insulin by: _____
Insulin Type:		<input type="checkbox"/> Adjust insulin dose by 1-2 units or up to 20% prn to achieve Diabetes Canada CPG glycemic targets of ac 4-7 mmol/L and pc 5-10mmol/L or individual target of: _____ or
Dose and Time:		<input type="checkbox"/> Adjust insulin by: _____
GLP-1: Type/Dose and Time:		<input type="checkbox"/> Adjust GLP-1 by: _____

Allow Certified Diabetes Educator to reduce the secretagogue dosage accordingly to avoid hypoglycemia
 Allow Certified Diabetes Educator to adjust carb/insulin ratios for self management of insulin therapy

CURRENT THERAPY AND MEDICAL HISTORY

Check all that apply and include types and dosages

Insulin Antihyperglycemic Agents

- History attached Retinopathy Obesity
 Hypertension Nephropathy Exercise restrictions
 CVD Neuropathy Alcohol Use
 PAD Gastroparesis Tobacco Use
 Dyslipidemia Vegetarian Sexual Dysfunction
 TIA/Stroke Mental Health: _____ Foot ulcers
 Fatty Liver _____ _____

Test	Result	Date	Test	Result	Date
FBS			Creatinine		
2hr OGTT			T Chol/HDL Ratio		
A1C			Triglycerides		
ACR			HDL Cholesterol		
eGFR			LDL Cholesterol		

Endocrinologist/Specialist in Diabetes Consult _____ Nephrologist/HTN Clinic Consult _____
 Ophthalmologist Retinal Screening/Consult _____
 Medically Supervised Wound Care Consult _____ **If requesting consult, provide your billing number _____*

Signature: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Address (stamp): _____

For Internal Use ONLY

DEP:
Specialist:

For DEP Use ONLY

First Contact:
Appointment Dates: